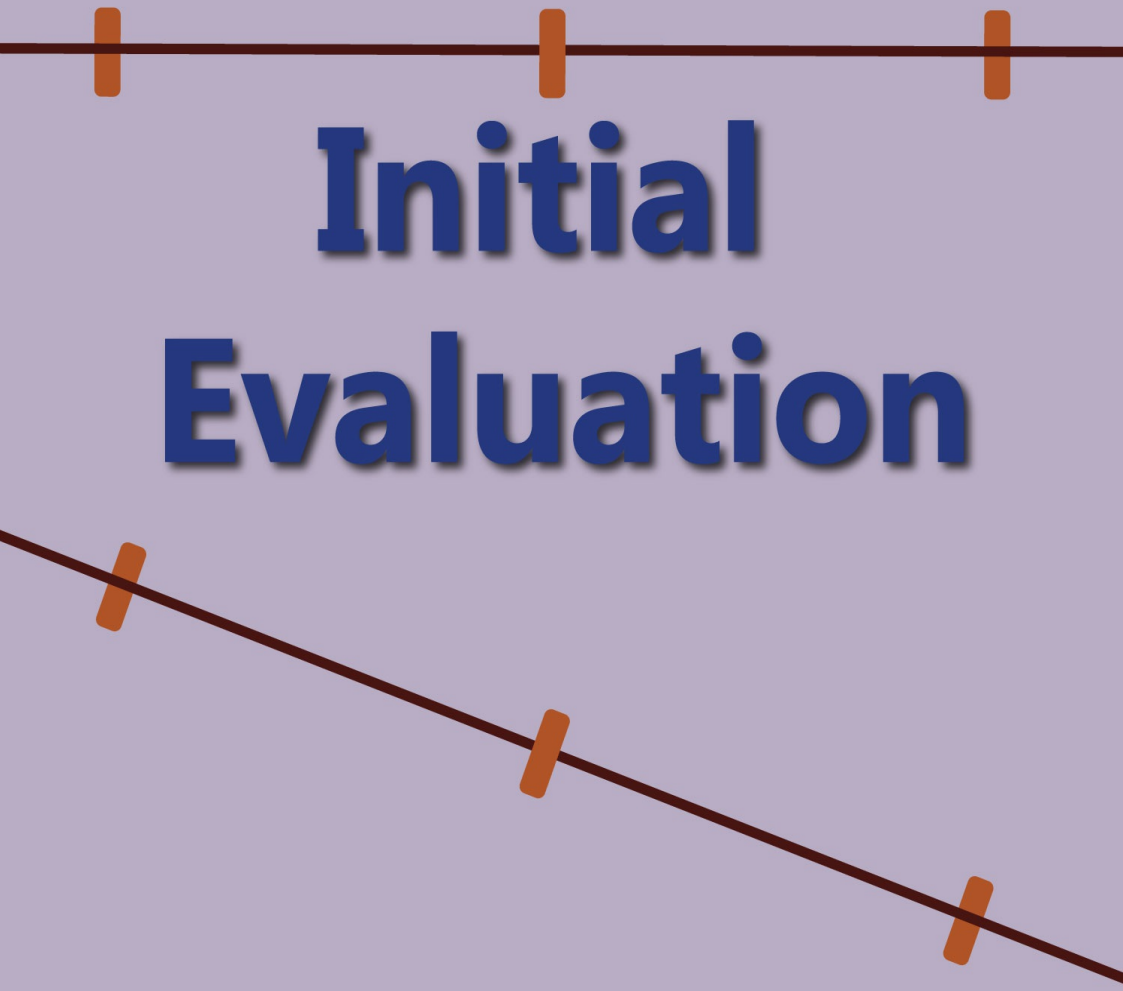
A Child Psychotherapy Primer



Initial Evaluation

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Table of Contents

INITIAL EVALUATION

HOW IS A CHILD EVALUATED IN A PLAY SESSION?

How one evaluates a child in a play session—that is, what information is sought, what behavior is noted, and particularly, how these are organized and interpreted—will depend to a large extent on one's theoretical orientation. The ego psychologist and the behaviorist will attend to different data or use the same data in different ways. However, the attempt here is to pull together some of those aspects of the child about which one may learn in a play session within a broad developmental theoretical framework. Later in this section the different uses of play session data within the psychoanalytic, phenomonological, behavioral, and cognitive models are noted.

Like the psychological test, the play interview is simply a way to obtain a sample of the child's behavior. The tasks presented to the child in a play interview are, of course, less structured than in tests. Nevertheless, the play session is far from unstructured and far from the child's natural life settings. Some child clinicians (e.g., Swanson 1970) feel that the evaluator should be more directive than the play therapist. The arguments are that the evaluator wants specific information (about family, school, friends, pets, etc.) and productions (drawings, wishes, ambitions, etc.) that, given a totally nondirective session, the child is not likely to produce. Not only is the information useful to understanding the child but so is the child's reaction to the request: refusal, hesitancy, anxiety, ready compliance, eagerness to please, and so on.

To evaluate a child, to know the meaning of the child's appearance and behavior, the clinician must have developmental norms in his/her head. The beginning clinician using standardized tests has the obvious advantage over the clinician gathering data in a play session in that the norms for the tester are all printed out in the tables. However, the well-standardized tests do not cover vast areas of personality, social, cognitive, and physical development, nor do they help in the kinds of judgments the skilled child clinician makes about synchronization and dyssynchronization of various aspects or lines of development and functioning within the child. Much guidance for the interpretation of the

developmental meaning and appropriateness of the child's behavior in a play session may be found in the child development literature covering major developmental milestones (physical and motor development, cognitive stages, language, friendship patterns, parental relationships, etc.). However, the child clinician must acquire a far more refined sense of what is appropriate for children of different ages and how the different areas of the child's functioning work together. Generally, this knowledge is acquired through many, many hours of contact with children.

Here are some things a clinician might learn about a child in a play session:

1. The child's physical appearance will of course be noted immediately. The child's size and shape, how dressed and groomed, racial features, posture, and visible handicaps are all important in terms of the child's self-view and in terms of how others react to the child. Sometimes the child's appearance will suggest some physical problem, chronic or temporary. A few possibilities might be a jaundiced appearance, bruises, red eyes, or very lethargic behavior. If the clinician receives any suggestion of a physical problem, then collaboration with a physician is essential. Mental health professionals cannot afford to ignore the whole child; the physical condition has profound influence on the psychological condition.

2. The child's response when invited to leave the waiting room and to separate from the mother (or other familiar adult who brought the child) to come with a strange adult into a strange room will provide a wealth of information about the mother-child relationship, the child's way of responding to strange adults, the child's fear-adventure balance, individuation, and self-confidence.

3. Gross motor development will be noted as the child moves to the playroom. As the child manipulates the various play materials, note can be made of his/her fine motor skills. Of greater importance, perhaps, than the level of motor skill (unless it is far below expected age level) is the child's energy level. In a play session one notes how vigorously or lethargically the child moves about in the room and manipulates toys. *Caution:* Activity level in the playroom has many possible interpretations. If the child is at the high end of the energy scale, it may be because of anxiety about being in a strange room with a strange adult (state) or it may be a reflection of the child's usual level of activity in many settings (trait). Similarly, if the child operates at a low activity level, it may be the child's reaction to a new setting.

For example, the child's style of coping with new situations might be characterized by a cautious approach or the child might be fearful of the examiner.

An example of low activity level that may arise more from internal than situational factors would be a child who cannot give him/herself permission to intrude into the environment (see Erik Erikson's 1959 description of modality for stage III, intrusion). The careful clinician will collect information on activity level over several sessions and check with the mother or others who know the child as to the child's activity level in a variety of other settings.

4. Habits and mannerisms that might interfere with the child's social or personal functioning should be noted, e.g., tics, behaviors that are socially disapproved, style of eye contact, etc.

5. How the child copes with a strange room, with a strange adult, and with unstructured instructions such as "You may play with whatever you wish" will reveal a great deal about the child. (For an extensive discussion of coping styles you are referred to Lois Murphy 1962; pp. 6, 7, 74, and chap. 15).

6. It is important to note the child's mood during the session as well as shifts in mood: fear, sadness, exuberance, boredom, excitement, and the like. The degree to which the child appears to be suffering from the presenting problem also should be judged.

7. If the child is nonverbal during the play session, the clinician should note the following: (a) what the child chooses to play with; (b) the content of the play (themes); (c) the mode of the play (see Erik Erikson 1959 for modes and modalities such as suspicious, retentive, intrusive, making); (d) the child's impulse-control capacities; (e) the child's ability to concentrate and hold attention; (f) the emotions the child expresses, either directly or through the play; and (g) the child's actual competence and perceived self-competence in dealing with the playroom situation and materials.

8. If the child is verbal during the play session, the clinician, in addition to noting the above, can often obtain much of the following: (a) the child's fears, (b) the child's wishes and dreams, and (c) the child's perception of his/her relationships with and his/her attitudes toward parents, siblings, peers, teachers, and self.

9. The child's relationship with the clinician may be revealing of how the child relates with other adults: how dependent, how fearful, how trusting, how much involvement with the clinician, how much the child seeks to please the clinician, how much the child seeks approval from the clinician. *Caution:* If the child is of a different racial, ethnic, or social class background from that of the clinician, then the meaning of the child's behaviors with the clinician and with the play materials must be interpreted in light of the child's reactions to these differences and of his/her own cultural norms. When the clinician is unfamiliar with the expected behavior of children in a particular group and typical reactions to outgroup members, it is incumbent on the clinician to obtain consultation from professionals who are familiar with the racial, ethnic, or social group to which the child belongs. If the clinician judges the child according to the clinician's own group norms, some gross misjudgments might be made in such areas as trust, deference, intrusiveness, exploratory behavior, and language development.

10. The manner of the child's behavior toward the clinician and with the play materials can often give clues as to the degree of egocentrism versus allocentrism in the child's perception of self and the world.

11. A notion may be gained by observing the child at play, particularly if the child is verbal, as to the child's level of cognitive development. Clues come from how the child organizes the materials, how symbolic the child's productions are, and how elaborate the child's fantasy associations are. *Caution:* Do not fall into the trap into which many child workers fall, namely, the belief that verbal fluency is positively correlated with intelligence. Observing the child play with standard play items in a standard playroom is not a very reliable or valid way to obtain a notion of a child's level of cognitive development. Special materials are needed to test such Piagetian concepts as conservation, object permanence, classification, and level of representation; to test cognitive styles such as focal attention, field articulation, levelings, sharpening, and equivalence range; and to test "general intelligence."

From the point of view of a developmental model, the information about a child obtained in a play interview can be extremely useful in constructing a profile of the child's functioning across many areas of development. In addition to the child's appearance, the content of the child's problems, and the perceptions the child has of self and important interpersonal relationships, the clinician can obtain an indication of the child's age level in the following developmental lines: attachment and individuation

from mother, coping with new environment, coping with strange adult, language usage, modality of expression (action, fantasy, language), play content, play organization, attention span, fears appropriate to age, perception of time, and emotional independence.

In assessing a child brought for professional help the clinician will, of course, not rely exclusively on the play interview material to make intervention recommendations. The child may function quite differently in different settings, and the clinician should attempt to ascertain how the child adapts in other environments. The play interview, for example, does not yield very good information about a child's social skills with peers, about his/her behavior within the family , or about the details of his/her cognitive development. Also, the play content in an initial session is often devoid of significant emotional content or perceptions of phenomena in the child's life outside the playroom. To assess these areas the clinician would consider other data-gathering techniques such as parent interview, teacher interview, family session, home observation, school observation including free play with peers, and special cognitive tests and projective tests.

If, on construction of a developmental profile, the child shows some lines of development far deviant from others, the clinician might wish to use the GAP diagnostic label "Developmental Deviations, deviations in maturational patterns" or one of the Axis II Developmental Disorders in DSM III. From the developmental point of view, however, constructing a profile will enable the clinician to move far beyond a diagnostic label and into recommending some intervention strategies based on the child's strengths and weaknesses and knowledge of the settings in which these strengths and weaknesses are exhibited.

Although the play interview method lends itself well to a developmental model, it does not lend itself equally well to use within all psychological models. Child evaluators with a psychoanalytic ego-psychology orientation and a phenomenological orientation will find the technique more useful than will the cognitively or behaviorally oriented evaluator. Below is a brief indication of how an evaluative play interview might be used by theorists of the four major schools.

Psychoanalytic Ego Psychology Theory

The ego-psychoanalytic theorists would take special note of material from which could be inferred

the child's level of psychosexual development, predominant modality, sexual and aggressive drive level, guilt, object relations and range, and strength and modulation of defenses. For an elaboration of how a child's play productions can be used to assess these constructs, see Menninger Foundation, Children's Division (1969, pp. 176-213) and Freud (1977).

Phenomenological (Humanistic-Existential) Theory

The phenomenological theorist would make a special effort to understand the child's phenomenological interpretation of his/her world. This theorist would attempt to understand the child's level of self-awareness and experiences and the degree of his/her sensitivity to these experiences. The existential-humanist would look to find any factors that might block the child's effective functioning and growth in interpersonal relationships and in manipulating the environment. Of particular interest to the phenomenological theorist would be the child's concept of self. Actually, a formal evaluation such as obtained in the kind of evaluative play session that has been discussed here within the developmental framework is not that important for the existential-humanistic child therapist. That is, without evaluation the therapist of this persuasion would immediately set out to create the accepting atmosphere within the playroom wherein the child could learn to accept him/ herself and unfold his/her growth potential (see Moustakas 1953, 1959, and Axline 1947).

Behavior Theory

The behavior theorist is less likely to use the play interview as an evaluation technique than is the developmental, phenomenological, or psychoanalytic theorist. The preferred technique would be to inquire about or observe the child in real-life situations in order to discover the environmental stimuli and reinforcers of the target behavior. If the child were seen in a play session, the behavior theorist would focus on the events surrounding and triggering the primary symptom (e.g., aggressive behavior, spacing-out episodes, habits, overdependency) and possibly also discover what reinforces the behavior. A description of the child or a developmental profile evolved from a play interview would not be focused enough to be very useful to the behaviorist.

Cognitive Theory

The cognitive theorist would probably need special equipment in order to ascertain the child's cognitive constructs, particularly if the child were nonverbal. If the child talks, the examiner would ask specific questions designed to learn the child's constructs and developmental level of cognitive functioning. If the child were nonverbal, special equipment would be needed to determine the constructs a child is capable of using. For example, one cannot judge a nonverbal child's capacity to classify if the child does not have classifiable objects in the playroom to manipulate. The cognitive theorist would tend then to move from an unstructured play interview to a structured, task-oriented interview much like a psychological test (see Santostefano 1971).

WHY MAKE EVALUATION AND THERAPY SEPARATE PROCESSES?

The answer to this question depends on the model and the operation of the clinic or child clinician. Certainly if the clinic's or clinician's practice is to make a formal psychodiagnostic classification of the child's disorder, then a time is set where all available information is examined and a diagnosis determined. The diagnostic and treatment processes are generally viewed as discrete operations.

On the other hand, a case may be made that treatment begins from the first contact the family has with the clinic or clinician and that evaluation goes on continually throughout treatment. The clinician certainly has an impact on the child during the initial contacts, and the process may prove helpful to the client. Other clinicians must have shared my astonishment when, after one or two sessions, a client offers thanks for curing the problem when the intent has been simply to evaluate the problem. During treatment the therapist should be continually formulating hypotheses and checking them out against the continually accumulating data from the therapy sessions, a kind of continuous diagnostic process.

Even if one views evaluation and treatment as one continuous process, it is useful to set some point in time at which those involved with the referral problem sit down with all of the accumulated information, formulate for themselves the reasons for the difficulty and plan what interventions may be helpful. This session may be with or without the family but certainly must include the family in implementing any treatment plans. If this discrete step is not taken, the child clinician might drift into work with the child with no clear understanding—and certainly no clear understanding on the family's

and child's part—about just what the purpose of the play sessions is. Without such a purpose it is difficult to know what progress has been made and when treatment should be terminated.

WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF THE SAME PERSON DOING THE INITIAL EVALUATION AND SUBSEQUENT TREATMENT?

Advantages of the same clinician doing the initial evaluation and subsequent treatment are as follows:

1. The clinician quickly acquires knowledge about the child, especially if projective techniques have been used.

2. The therapist obtains assessment information directly and not secondhand from the assessor. If another person assesses the child, invariably some knowledge of the child acquired by the assessor is lost in either oral or written transmission to the therapist.

3. The child does not have to terminate with one adult, the assessor, after the assessment sessions and then start all over with another adult, the therapist. If a positive relationship has built up between the assessor and the child, then the therapy work can begin sooner, since rapport building will not have to be done anew with a different therapist.

4. Parents might feel a better sense of continuity with their clinic contacts when they deal with only one person. They often resent having to "tell their tale" all over again with a new person.

Disadvantages of the same clinician doing the initial evaluation and subsequent treatment are as follows:

1. In the assessment the child learns one mode of interaction with the clinician, namely, sitting still for tests, giving information, keeping attention focused on task, and the like. The assessor will have set up these expectations for the child and perhaps have had to work at enforcing them. If the child begins therapy with the play method, the rules are all changed and there is less structure, less sustained focus, less question-and-answer—in short, less authoritative behavior by the adult. The child may be confused by this. It might be noted, though, that it is much easier for the child to adjust to an adult moving from a more structured and directive rule to a less structured and nondirective rule than vice versa. This is a strong argument for obtaining an assessor different from the therapist if testing is done after therapy is under way.

2. If the therapist uses an existential, nondirective model, then assessment procedures that are directive, intrusive, and not entirely open as to intent would go against the grain for the therapist. Such a therapist, however, might make use of another clinician's assessment without violating how he/she prefers to relate to the child.

3. If the child or family disagrees with the assessor's conclusions, they may not wish to work further with the assessor but might still be willing to work with another clinician at the same agency.

4. The information gathered from the child during an assessment is generally more widely discussed in psychological reports to parents and outside agencies than is information gathered during therapy. This openness might undermine the level of trust needed for a therapeutic alliance. With different clinicians doing the assessment and the treatment, this potential source of mistrust of the therapist by the child is reduced.

5. The use of another clinician to do the assessment can give the therapist additional information. The assessor and the therapist might see the child's conflicts, problems, feelings, strengths, and development somewhat differently, and these differences could broaden the therapist's understanding. The therapist might have some "blind spots" in viewing the child that could become evident through a thorough assessment. As the therapeutic relationship builds, the therapist in turn may perceive aspects of the child that the assessor missed. The point here is that two heads are better than one.

SHOULD PSYCHODIAGNOSTIC TESTING TAKE PLACE IN A PLAYROOM?

Testing a child in a playroom can present some problems. It may make little difference for the older child (except that the child may feel insulted at having to use the little kid's room) or the younger child who has good impulse control and attention-focusing skills. However, the usual playroom materials might interfere with standard testing procedures. They undoubtedly seem much more interesting than the test materials or the "dumb" test questions. Even if the child resists getting up to play with the material, the tension created in the child by such temptation could depress the child's test performance. If the only room available for testing the child is a playroom, the examiner would avoid potential problems by removing from sight as much of the play material as possible.

In a few cases, however, it may be preferable to use a playroom for psychodiagnostic testing. Sometimes children will not cooperate with the testing when given in the standard manner. The child

may have, for example, a strong need to control situations and be unable to tolerate taking another person's direction, or the child might be so angry at the parents for making him/her come to the clinic that he/she refuses to respond to the examiner. In such cases the child might need to proceed on his/her own terms, perhaps giving the examiner test items or leaving the testing situation altogether. In such cases the examiner may slip items into the free play, e.g., building a block bridge (Stanford-Binet, age 3) or introducing the Rorschach plates after making inkblots together or taking turns giving each other words to define. For an excellent presentation of case material illustrating such an approach see Kaplan (1975). In these kinds of cases, it may be desirable to conduct the diagnostic testing in a playroom to allow easy flow between structured and unstructured interactions.

HOW CAN YOU EFFECTIVELY PRESENT TO THE PARENTS INFORMATION ABOUT THE CHILD?

The usual occasions when the child clinician gives psychological information to the child's parents are in an interpretive session after the initial assessment period and periodically during the course of psychotherapy. The primary goal of these occasions is, of course, for the parents to receive information that will help them better understand their child. Frequently, a second goal of the clinician is that the parents change their attitude toward and their behavior with the child in order to help the child achieve a better adjustment.

In order to set the stage clearly at the beginning of the interpretive session I often make a comment like, "I ["we" if the evaluation was done by a team] have been collecting all kinds of information from you and Susan; now it is time to reverse the flow. I'll tell you how I see Susan's strengths and difficulties, and you will have a chance to ask the questions. Then hopefully together we can figure out how best to help Susan." Some such statement ought to put the parents in a receptive mood but also let them know that you do not have any magic answers and that you need to work together to find solutions. In fact, it may be helpful to acknowledge the parents' and your wish for easy solutions but that the reality is not so simple; otherwise the parents would not need outside help. It might be useful also to mention that the child's problems were many months or years in the making, and it will take time and much effort to help the child effectively deal with these problems.

The most frequent mistake beginning therapists make in feedback sessions to parents is to give too

much information too fast for the parents to absorb. The clinician has had a great deal of time to digest information and construct a picture of the child. To give this in one large piece to the parents may just overload their systems. A strategy that I have found effective for avoiding this is to have in mind three or four of the main points about the child that I then present one at a time. After presenting each point I ask if the parents have seen examples of it. Most often the parents will see the point immediately and come up with several examples. In this way they incorporate what I am saying into their own experiences with the child. On those occasions when they do not see what I am saying about the child, the point needs further exploration. Perhaps the parents have, for their own psychological reasons, a blind spot in that area. Perhaps the child reveals a conflict, an attitude or a feeling only through fantasy seen in the play session or on projective tests, and the parents have never seen it. Perhaps I am wrong about the point or it is a very minor part of the child's overall psychological functioning.

After the first point has been presented and mutually examined by the parent and myself, I present the second point in a like manner. If the session is for feedback to parents after an initial assessment of the child, a written report for the parents can be useful. During one assessment we noted that the parents had great difficulty in hearing what was being said to them, so a written report on the child was prepared to give them during the interpretive hour. Twenty minutes after the feedback session ended I saw them standing in the middle of the sidewalk in front of the clinic deeply absorbed in studying the report. In this day of open records you might consider routinely giving parents jargon-free reports on their child.

After you have conveyed to the parents the essence of how you see the problem, and you and the parents are in basic agreement as to the nature of the child's problem, then it is time to turn your attention to working out solutions. Since you are the expert, you need to have some alternative interventions in mind to suggest to the parents. The plan that is actually adopted will depend on the intervention alternatives available and the parents' time and psychological and financial resources. Beginning clinicians may not give sufficient weight to these realities in the parents' lives and may become impatient with parents who do not jump at what the clinician considers the ideal treatment plan. The child clinician should, in my view, be a child advocate but also needs to temper the advocate position with the realities of circumstances in the child's life. If the parents sense that the clinician understands their position as well as the child's, then planning together will undoubtedly go much more smoothly.

The parents are more likely to follow through with treatment plans they have helped formulate. The paradox here is that if the clinician is a bit less of an overt child advocate, the child may end up getting more.

Sometimes parents simply will not accept your assessment conclusions and recommendations. This might be the case where the child was referred by another agency, such as a school, and the parents felt forced into bringing the child to the clinic. Or perhaps the parents have some hidden agenda, such as wanting their unruly child to be hospitalized, or they might wish their child to be placed in a special program for the gifted or mentally retarded. If you try to convince the parents of the "correctness" of your conclusions and recommendations, the parents will most likely resist even more. So what can you do? It would be most constructive if you could align yourself with the parents as a person who shares their concern about the welfare of their child. You can try talking openly about their concerns and differences of opinion. In the final analysis, however, you are not going to be able to "sell" your recommendations. You can only state what you believe is best for the child and why and then let the parents do what they will.